

Arthritis Ireland
Inform. Enable. Empower.



When a Child has Arthritis





Arthritis Ireland helps people with arthritis take their lives back. We provide real solutions by empowering people with arthritis and those caring for them to take positive action to manage the effects of their disease on their lives.

Our innovative and life changing education and support programmes including *Living Well With Arthritis*, *Working with Arthritis* and *Breaking the Pain Cycle* give people with arthritis the knowledge and practical skills they need to live their best possible quality of life. Our helpline provides vital emotional and practical support and, because we know that knowledge is power and central to living well with arthritis, we provide an extensive range of free educational information, such as this booklet.

Through our work we campaign for increased levels of funding in rheumatology services to provide a world class service that will positively change the outlook and outcome of patients lives.

We also actively support and fund research into arthritis to ensure that Ireland is at the forefront of new breakthroughs leading to possible cures and also fund the training of health professionals through medical students in university to create a direct and positive improvement in patient care.

When you are told that your child has arthritis you will probably have mixed feelings. You may feel relieved. At last somebody has put a name to the illness your child has been suffering from for weeks or months and finally treatment can begin. You may also feel worried about the future, not knowing how arthritis will affect your daughter or son as s/he grows up.

You may feel angry or confused, wanting to know why your child should have an illness which most people think only happens to adults. Whatever you feel, you will probably have lots of questions. This booklet aims to provide some answers. It describes the different types of arthritis, outlines the best treatment, and offers practical advice on living with the condition. The booklet concentrates mainly on children up to about 13 years. There is a separate booklet, '*When a Teenager has Arthritis*', for 13-20 year-olds.

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THE BASICS

What is juvenile idiopathic arthritis (JIA)?

Arthritis in children is now called 'juvenile idiopathic arthritis', or JIA. It is really a group of illnesses which doctors have put under one name because they share similar symptoms.

What does juvenile idiopathic arthritis mean?

Although it seems a clumsy name, juvenile idiopathic arthritis simply means arthritis with no known cause in children or young people under 16. The word 'juvenile' means under 16 years, 'idiopathic' means doctors do not yet know what causes the illness, and 'arthritis' means one or more joints – such as the knee, elbow or wrist – are inflamed (swollen, painful and/or stiff). Doctors use the term 'juvenile idiopathic arthritis' to mean arthritis which begins before a child is 16 and lasts more than 6 weeks.

What does juvenile idiopathic arthritis mean for my child?

You may not have heard of arthritis in children before. In fact, 1 in 1,000 children has JIA. Every year about 1 in 10,000 children in Ireland is diagnosed with the condition. It is almost as common in children as childhood diabetes. It can begin at any age, although it most commonly shows up in younger children. It can develop in boys or girls, although most types are more common in girls. For the vast majority of these children, arthritis is not the same as in adults. Having arthritis as a child does not normally mean your child will have arthritis as an adult.

There are still many gaps in our knowledge about JIA. Doctors do not know what causes it or why it happens in some children rather than others. There is no clear evidence that it is passed down through families, although we do know that a child's genetic (inherited) make-up has some part to play. There is no clear evidence it is caused by an infection, although scientists suspect certain illnesses may act as a trigger. The latest thinking is that JIA could be caused by an interaction between some aspect of a child's genetic makeup and other factors which act as a trigger.

'When my child was diagnosed with JIA I was shocked, finding out more information about the condition has made a big difference'

Juvenile idiopathic arthritis can be difficult to diagnose. Usually doctors come to a decision by checking symptoms, examining the child and, when necessary, doing tests which rule out other illnesses. There is no single test which gives a definite diagnosis of JIA. Different types of childhood arthritis have different symptoms.

Even though doctors are still unsure what causes JIA, we know a great deal about it and how to treat it. With the right management most children with JIA lead independent, active lives. Treatment of JIA has developed rapidly and new, better medicines are coming on stream all the time. There is every reason to believe that the treatment of JIA will continue to improve. But this is not an illness where parents should sit back and let doctors take control. The best care for your child is achieved through the whole family working together with health professionals to find the most suitable medicines, keep up the right exercises, and tackle other issues as they arise. You can make a real difference to the way your child comes through JIA.

What does the future hold?

Every child has a different illness and responds differently to treatment. So it is very difficult to predict how arthritis will affect your child. Treatment of JIA is improving all the time. There is no cure for JIA but many children go into what doctors call 'remission', which means their symptoms disappear, often forever. About 3 in 5 children with JIA (60%) will have few or no physical problems as adults. For the remaining children, arthritis can unfortunately cause some longer-term problems. They may have some joint damage which limits daily activities by varying amounts, and could develop thinning of the bones (osteoporosis) when older. Some may continue to need medicines to control their arthritis. A few may need joint replacements in adulthood.

The basics

- arthritis affects 1 in 1,000 children in Ireland
- there is no known cause
- it is different from arthritis in adults
- most children will not have lasting problems from childhood arthritis
- most children with arthritis will lead full, active lives
- the right medicines and exercises make a significant difference
- better medicines and treatments are developing fast
- involving the whole family in treatment is the best way forward.

WHAT ARE THE DIFFERENT TYPES OF JUVENILE IDIOPATHIC ARTHRITIS?

There are several types of arthritis grouped together under the umbrella term JIA. The symptoms vary between these. You may meet other families with children who have JIA or read about children in books or on the internet. It is important to realise that just because something happens to one child that does not mean it will happen to every child. The different types of JIA tend to have different patterns and effects. At the same time, each individual child will respond differently to their illness and medicines.

Oligoarthritis

Oligoarthritis is arthritis which affects between one and four joints in the first 6 months of illness. The word 'oligo' means 'few'. This is the commonest form of childhood arthritis.

About 3 in 5 children with JIA (60%) have oligoarthritis. It is the mildest form of childhood arthritis and is most likely to disappear as your child grows up, leaving little or no lasting damage. About 3 in 5 children with oligoarthritis (60%) never have more than four joints affected throughout their childhood. This is called 'persistent oligoarthritis'. These children generally recover with few or no lasting effects after 3-4 years, provided they have adequate treatment including physiotherapy and exercise to keep the joints and muscles healthy. Steroid injections into the joint can be very effective in this condition.

For the remaining children, the disease spreads to more joints after the first 6 months. This is called 'extended oligoarthritis'. Oligoarthritis is most common in girls under 5. It most commonly affects the knee, ankle and wrist joints but may affect the elbows and small joints of hands and feet. In young children the first sign



for parents may be when a child stops walking after learning to toddle or else never takes to walking. Some children with oligoarthritis do not complain of pain but they can seem moody and difficult. Stiffness of the joints in the morning is quite common.

Although this is the mildest form of childhood arthritis, it does carry the highest risk of developing eye problems, called 'uveitis'. This is inflammation in the eye, which can cause permanent damage and even blindness if not treated early. Usually there are no symptoms until damage has been caused. Most children with JIA need regular checks for uveitis. This is vital in children with oligoarthritis as about 1 in 5 (20%) is at risk of uveitis. Children with oligoarthritis who carry particular antibodies in their blood, called 'antinuclear antibodies' (ANA), are at most risk. Regular eye examinations must be done by an ophthalmologist using a special microscope called a 'slit lamp'. Once spotted, uveitis usually responds well to treatment.

Polyarthritis

Polyarthritis is arthritis affecting more than four joints in the first 6 months. The word 'poly' means 'many'. About 1 in 5 children with arthritis (20%) has polyarthritis. It is the second commonest type and is more common in girls than boys. Doctors divide this type into two groups: children who test negative for the rheumatoid factor (RF) antibody, and those who test positive. A blood test is often carried out to check for RF, particularly in older girls who are the most likely to be positive.

1. Polyarthritis (rheumatoid factor negative)

Most children with polyarthritis are RF-negative. This form of childhood arthritis can start at any age. Often it affects the joints of the hands and feet, which become painful, swollen and stiff. It may affect the hips, knees, neck, elbows, shoulders or jaw. The tendons in the hand can also become sore. In some children several joints become sore and swollen at the same time, while for other children the illness develops in one joint after another. For some it is a very mild illness. It can be more severe in others. Soreness in the joints can lead to difficulties walking or writing, although careful treatment can reduce these problems. Children with polyarthritis can seem generally unwell and may develop a fever when their joints are affected, but this is not the very high, daily temperature seen in systemic arthritis (see below).

About a quarter of children with RF-negative polyarthritis will go into remission, while the rest will continue to have some joint problems.

2. Polyarthritis (rheumatoid factor positive)

About 1 in 10 children with polyarthritis (10%) will have a test which shows positive for rheumatoid factor. This means their blood contains an antibody which is similar to that found in adult arthritis. Overall, this is less than 5% of all JIA. Most children who are RF-positive are girls, usually aged 10 or older. Early treatment is important to slow down the disease and prevent long-term damage.

This group of children can have quite a severe form of disease which needs to be actively treated with medication to avoid damage to the joints.

'It can be difficult as a parent knowing that your child may be in pain; talking about it together helps'

Systemic arthritis

About 1 in 10 children with JIA (10%) has systemic arthritis. The word 'systemic' means affecting the body as a whole rather than only particular parts of the body. It occurs in boys and girls equally and frequently starts in the under-5s. This is the most difficult type of childhood arthritis to diagnose and children may be ill for some time before doctors make a definite diagnosis. The symptoms may be confused with other illnesses like measles, meningitis or leukaemia. This means parents may have a long and worrying wait before they get any real answers. You may find it is a relief to hear that your child's illness is not something more serious than feared.

Systemic arthritis usually begins with a particular kind of fever lasting several weeks. Typically, the child has a very high temperature (up to 40°C, or 104°F) once, or sometimes twice, a day, often in the evenings. Parents usually notice a blotchy, salmon-pink rash on the child's thighs, arms or body. This often appears at the same time as the highest temperature. Glands in the neck, armpits and groin may be swollen. Very occasionally, the inflammation can affect the covering of the heart and, even more rarely, the covering of the lungs. Not surprisingly, children with systemic arthritis may be generally miserable, irritable and off their food. Problems with the joints may appear later.

Since systemic arthritis is difficult to detect, children are usually admitted to hospital for tests. There is no single laboratory test which can show up systemic arthritis. Only by ruling out other illnesses can doctors be sure of diagnosis. This round of tests can be difficult for the child and hard for parents. But once systemic arthritis has been confirmed, treatment can begin quickly to bring down the fever and make the child feel better.

Some children recover after one bout of systemic arthritis and suffer no long-term problems. Others will have repeat episodes of illness, or 'flare-ups', for several years. Some go on to develop arthritis in many joints – polyarthritis – without further fever attacks.

Psoriatic arthritis

Psoriasis is a scaly skin rash which sometimes appears with childhood arthritis. Doctors may spot signs of psoriasis in the fingernails and toenails. The arthritis associated with psoriasis can start before a child has ever had psoriasis of the skin. Sometimes the fact that another member of the family has psoriasis suggests that psoriatic arthritis is the cause in the child's case. Often arthritis only affects the fingers and toes, but it may affect other joints too. It is more common in girls and typically starts at around 8-9 years. Less than 1 in 10 children with arthritis (10%) has psoriatic arthritis. These children may also get uveitis.

Enthesitis-related arthritis

Enthesitis-related arthritis usually affects boys over 8 but can occur in girls, and in younger children as well. As well as arthritis in several joints, there is usually swelling at the point where the tendons are attached to the bones (this is called 'enthesitis'). This type of arthritis mainly affects the lower limbs, in the hips, knees, ankles and sacroiliac joints (where the base of the spine joins the pelvis). About 3 in 4 children with enthesitis-related arthritis (75%) carry a particular genetic marker, the HLA-B27 gene. A few children with enthesitis-related arthritis may develop the condition ankylosing spondylitis as adults (which involves the same gene), but most do not.

Children with enthesitis-related arthritis can also get problems with their eyes – typically this is a painful, red eye condition called 'iritis' (acute anterior uveitis) – but this is not as common as the eye disease associated with oligoarthritis. Children with enthesitis related arthritis often have their eyes regularly checked by an ophthalmologist. If they develop a red or painful eye between appointments you should take them for an eye check as quickly as possible.

Other arthritis

This really is a catch-all group for children whose arthritis does not seem to fit into the other types. It may not seem a very useful category, but it is one which doctors sometimes have to use.

HOW IS JUVENILE IDIOPATHIC ARTHRITIS DIAGNOSED?

How do doctors detect juvenile idiopathic arthritis?

It can be very difficult to detect JIA in the first place. This can be frustrating and worrying when you really want to know why your child is ill. But once doctors come to a decision (a diagnosis) treatment can start straight away. Different types of childhood arthritis have different symptoms, and these often vary from one child to another. As there is no foolproof test to indicate JIA, doctors have to base their decisions on what you tell them about your child, what they find by examining your child, and on tests they carry out to rule out other possible illnesses.

What blood tests does my child need?

Doctors will try to do as few tests as possible to allow them to be sure of their diagnosis. Even so they may need to do some blood tests to make various checks and these may need repeating to keep a watch on the condition. This can be upsetting for children and for parents. But normally an anaesthetic cream (such as Ametop or Emla), or 'magic cream', is put onto the skin to numb the area before blood is taken so the child should not feel anything.

The most common blood tests are:

- **Full blood count (FBC)** – measures haemoglobin (a substance contained in red blood cells) to find out whether your child is lacking in iron (anaemic). It also measures the number of white cells and platelets, which may be high (raised) if your child has inflammation.



- **Erythrocyte sedimentation rate (ESR)** – measures how quickly the cells in the blood settle when they are left to stand in a tube. This shows how much inflammation the arthritis has caused. The measurement will improve as your child's arthritis improves.
- **C-reactive protein (CRP)** – measures concentrations of this protein in the blood as an indication of inflammation or disease activity.
- **Urea and electrolytes (U&E)** – measures how well the kidneys are working.
- **Liver function tests (LFT)** – measure how well the liver is working.
- **Autoantibodies** – checks for certain antibodies. Antibodies are produced by the body to fight infection. Sometimes antibodies are produced which may fight parts of the body's own cells or tissues and these are called 'autoantibodies'. If your child has polyarthritis, laboratory staff may check for rheumatoid factor (RF) to see whether s/he is RF-positive or negative. They will also check for antinuclear antibodies (ANA), especially if your child has oligoarthritis, to find out whether s/he is at greater risk of eye damage.

What other tests might my child have?

If doctors suspect systemic arthritis your child will undergo several tests to rule out other, more serious, illnesses. This may include taking a bone marrow sample to rule out leukaemia.

Some hospitals use magnetic resonance imaging (MRI) or ultrasound (US) scans to check how much a joint is

affected. Because children have to keep totally still for MRI scans, they may be given a drug to sedate them or a general anaesthetic beforehand. As MRI and US scans do not use harmful radiation they are safe for children.

X-rays of affected joints are often done when the child first comes to hospital. But if the diagnosis is unclear at the start of the condition, x-rays or a test called a 'bone scan' may help to exclude more serious illnesses which can cause pain in joints or bones.

Why are eye tests important?

It is essential that regular eye checks are considered for all children with JIA. Children with arthritis are at risk of inflammation in the eye (uveitis). As this is painless and is not normally noticed until damage has been done, regular tests are needed to spot it early on. If left untreated uveitis can cause blindness. Now that children with arthritis are regularly given eye tests, blindness is very rare. If your child has oligoarthritis and the antibody which indicates a greater risk of uveitis, s/he should have tests regularly (for example every 3 months). Other children should have their eyes checked as soon as possible after diagnosis and then when the ophthalmologist advises (this may be, for example, every 6 months).

The eye checks are painless, although your child may find them a bit uncomfortable or simply not want to sit still. The ophthalmologist will check your child's general vision, then examine your child's eyes for signs of uveitis using a special (slit lamp) microscope. The ophthalmologist may also put in drops to enlarge (dilate) the pupil to look at the back of the eyes. This can sometimes cause blurring for a while but should clear in a day or two.

If the checks show up uveitis, your child will need eye drops to treat the problem. Drops containing steroids may be given. Steroids taken as tablets can have long-term side-effects but with eye drops almost none of the steroid is absorbed into the rest of the body. Drops to enlarge the pupil and prevent the swollen iris sticking to the lens are sometimes given. Your child may need drops to reduce the pressure inside the eye if this is high. Most children with uveitis are treated successfully and after a while treatment can be reduced or stopped completely.

HOW IS JUVENILE IDIOPATHIC ARTHRITIS TREATED?

What is the best treatment for my child?

The key to the best care for your child is early treatment with effective medicines and an active exercise programme. Although sometimes in healthcare it is best to 'wait and see' how an illness develops before starting treatment, JIA is different. Making sure your child has the best treatment as soon as possible will slow down the disease and reduce long-term damage to his or her joints. In the same way, starting exercises early and keeping them up will make your child as mobile as possible and protect his or her joints from damage. Your child's response to treatment and the progress of his or her illness needs very careful watching over a long period.

'Finding out what tests were needed and what each one did really helped us understand what was happening and why'

The best way to provide this package of care is through a team of health experts working together (a multi-disciplinary team). This will probably include your family doctor (GP) and hospital doctors who specialise in rheumatology (rheumatologists) and children's medicine (paediatricians). You may see a specialist who is expert in both (a paediatric rheumatologist). You should see an eye specialist (ophthalmologist) for eye checks. A few children may need to see a surgeon (orthopaedic surgeon). Your care may be shared between your local hospital and a



specialist centre further away. As well as doctors, your child should see a physiotherapist regularly to advise on a home exercise programme. The team may also include nurse specialists, occupational therapists, social workers and psychologists. The team should work together with you as parents and your child's school to provide the best all-round care and to help you cope with the effects of the illness on the whole family.

What medicines will my child need?

The aim of medical treatment is to relieve your child's pain, reduce the swelling or inflammation in his or her joints, and slow down the advance of arthritis. New medicines today are very effective at doing these things. There is no 'wonder drug' which can cure JIA but doctors take care to use the medicine which works best to control arthritis in your child with the fewest side-effects. There are several kinds of medicines involved:

Non-steroidal anti-inflammatory drugs (NSAIDs)

NSAIDs help reduce pain, stiffness and swelling (inflammation), which helps prevent lasting damage. It is important that your child has a large enough dose of NSAIDs to be effective. Check with the doctor to ensure that your child is taking

the right amount. The most commonly used NSAIDs are ibuprofen (e.g. Brufen, Junifen and Nurofen), diclofenac (e.g. Voltarol), naproxen and piroxicam (e.g. Feldene). Most are taken by mouth in liquid or tablet form. Most children with JIA take NSAIDs. If your child has only mild arthritis, this may be the only medicine they need.

What are the side-effects?

Every medicine has some side-effects but these are not normally too unpleasant or harmful with NSAIDs. They may include loss of appetite, tummy pain, rashes – especially when out in the sun – and if your child suffers from wheezing this may increase. Talk to your doctor if you notice any of these. Occasionally they may cause some inflammation in the kidney.

'We keep an eye on how medication affects our child and keep the doctor informed'

Disease-modifying anti-rheumatic drugs (DMARDs)

These medicines slow down the progress of arthritis and may even stop it in its tracks. They also reduce pain, swelling and stiffness. They act slowly, usually taking weeks or months to take effect. They may be used early to reduce the impact arthritis will have on your child or as a second line of defence if NSAIDs are not working.

The most commonly-used DMARD is methotrexate. This has made a vast improvement in the treatment of JIA. Methotrexate is used in children with active extended oligoarthritis, polyarthritis, systemic arthritis, psoriatic arthritis, enthesitis-related arthritis and uveitis, and more than two-thirds of children respond very well. It is taken weekly as a tablet, liquid, or as an injection under the skin (subcutaneously). Parents can be taught to do these

injections, if they wish, and older children can learn to do them for themselves. Methotrexate takes 3-12 weeks to start working so it is worth persevering. Other DMARDs which are occasionally used include sulphasalazine, which works well for boys with enthesitis-related arthritis who carry the HLA-B27 gene, and cyclosporin. Other DMARDs, such as penicillamine, gold and hydroxychloroquine, are used very occasionally.

What are the side-effects?

As with all drugs, methotrexate has side-effects. The most common is feeling or being sick, just before or after taking the weekly tablets. Although unpleasant, the sickness is not harmful. Many children take the tablet on a Friday night or Saturday to avoid problems during school. Another medicine can be taken at the same time to ease the sickness. Less common side-effects are skin rashes, itchy skin, sore mouth, mouth ulcers or diarrhoea. Very occasionally, methotrexate can damage the bone marrow or liver. Your child needs regular blood tests to check for this. These are usually done every 2-4 weeks for the first 6 weeks and then monthly. The tests show up any risk before damage is done.

There are some extra points to consider if your child takes methotrexate. S/he should not have any 'live' vaccines, such as MMR, oral polio, BCG or chickenpox, while taking methotrexate. Sometimes it is possible to have the vaccinations before starting the medicine, so your child has protection from these illnesses. Anyone taking methotrexate should avoid alcohol or keep it to a minimum, as taking alcohol and methotrexate together can cause liver damage. More information about methotrexate is given in the section 'What about becoming a teenager?' later in this booklet.

The most common side-effects from sulphasalazine are feeling sick, headaches and diarrhoea. Skin rashes, tummy pain, mouth ulcers and feeling off food are less common. Side-effects from cyclosporin can include feeling sick, diarrhoea, swollen gums, tiredness and raised blood pressure. An increase in body hair is another possible side-effect. Your child should have blood tests to monitor the effects of these medicines. Talk to your doctor about any concerns over the side-effects of any of these medicines.

Steroids

Steroids reduce inflammation caused by arthritis. They can be given as tablets, as an injection into a vein (drip), or as injections into a joint. Steroid tablets are rarely given long-term to children with arthritis nowadays because they can have harmful, long-term side-effects. Occasionally, doctors may prescribe short courses of steroid tablets to dampen down a 'flare-up' quickly, perhaps if you are going on holiday or your child is taking exams. The commonest kind is prednisolone. Doctors may give your child steroids by drip (called 'methylprednisolone') if s/he is seriously ill or other drugs are not working. Children with systemic arthritis are sometimes given steroids by drip to reduce the fever quickly. Your child will stay in hospital while the medicine is given.

Local steroid injections into a joint are commonly given and are very effective. They can reduce pain and swelling immediately. This method concentrates the steroid where it is needed so that very little affects the rest of the body and harmful side-effects are avoided. Young children are usually given a light general anaesthetic for joint injections. Older children may have just a sedative. It may be a bit uncomfortable but should not be painful. Occasionally, doctors may remove the fluid which has collected inside a joint at the same time to reduce discomfort.

What are the side-effects?

Steroid tablets can cause lasting side-effects, including making your child more prone to infection and thinning of the bones. This is why doctors prefer not to give them to children over long periods of time. However, it is dangerous to stop taking steroid tablets suddenly. Your child should be given a 'steroid card' if on steroid tablets for any length of time. It is important to have this available if your child is ever seriously ill. Steroids by drip cause fewer side-effects but can also cause thinning of bones and lower the ability to fight infection. Side-effects from steroid joint injections are rare but can include thinning of the tissue under the skin (atrophy) where the injection takes place.

Biologics

New medicines called 'biologics' are proving useful in treating JIA. They work by blocking the process of inflammation. Etanercept (trade name Enbrel), is widely prescribed for children in Ireland. It is given by injection under the skin twice a week. It can be effective in 1-2 weeks. Currently, etanercept is mainly used when other medicines have failed. This biologic drug was the first to be made available for use in JIA but others are now in use and further new drugs are likely to be made available in the future.

What are the side-effects?

Etanercept may cause a blocked or runny nose, headache, dizziness, rash, abdominal pain or indigestion. It may also cause itching or swelling where it is injected. Scientists believe etanercept may lower ability to fight serious infection but so far there have been very few reports of infection in children treated with it. As it is a new drug long-term side-effects are not yet known.

Surgery

Most children with JIA never need an operation. Very few, with severe arthritis, do benefit from some form of surgery. When other forms of treatment have not worked, a surgical procedure can be very effective. When muscles or tendons have become too tight around a joint, a surgeon may perform a 'soft tissue release' to loosen them. This is most often done for hip problems. It is performed under general anaesthetic. When a joint becomes very painful and deformed after many years of arthritis, a joint replacement with an artificial joint may occasionally be necessary. Hip, knee and hand joints are the ones most often replaced and these operations too are done under a general anaesthetic. Joint replacements are usually done only after growing has stopped, otherwise it may be necessary later on to replace the artificial joint with a larger one. Although joint replacement is a fairly major operation, it can make a huge difference to a young person's life. A synovectomy, where the lining of a joint, or 'synovium', is removed under general anaesthetic, is performed very rarely these days, but can be useful for a child with one badly inflamed joint if local steroid injections have not worked well enough.



Why are exercises important?

Regular exercises are important for everyone and are a vital part of your child's treatment. Exercising helps to strengthen weakened muscles and build stamina. This will help your child to get swollen, painful joints moving again and slow down the effects of arthritis. Even children with severe arthritis can lead a full, active life with the right exercise programme. Your physiotherapist will show you initially how exercises should be done as well as give advice on equipment which may be useful. Your support in making sure exercises are kept up every day is crucial.

At your first physiotherapy appointment, the physiotherapist will assess your child's movement and tailor an exercise programme to your child's needs. The physiotherapist will show you how to supervise exercises at home. Making sure your daughter or son keeps up the exercises can be hard when family lives are already so busy. You may find your child is not always keen to exercise, especially when his or her joints are swollen or painful. It is vital to remember that exercises will help ease the pain, reduce the stiffness, and improve your child's prospects of an active, independent future. It is important too to keep positive about the exercises. Try to make them fun for young children – part of play – and not a chore. Ideally your child should exercise every day, and it is often easier to keep to a daily routine, although some families prefer a Monday to Friday programme with weekends off. You

may find a regular session at the same time every day works well – perhaps before a favourite TV programme. Stretches first thing may also be helpful to ease morning stiffness, especially in a warm bath. Some families find that a star chart or special treats are helpful in rewarding the child. You should also encourage your son or daughter to take part in sports. Any physical activity, apart from rough contact sports like rugby, is good exercise.

Swimming, cycling and walking are all useful. School support and encouragement for a child's exercise programme is really important. Your physiotherapist may contact your child's school to discuss how s/he can take part in physical education (PE) classes. There is no reason why your child should not do these just like his or her classmates. Often exercises can be incorporated into PE or sports sessions at school, or they can be done with a special needs assistant. Some hospitals offer special warm-water exercises (hydrotherapy) in a special pool. This is excellent as the water supports your child while exercising. But swimming in an ordinary pool is also very good.

'Exercise is just part of our routine now, our son really enjoys it'

What equipment might help my child?

Your physiotherapist or occupational therapist can advise on different ways to help your child keep mobile. Special equipment, like wheelchairs, crutches and splints, should be avoided where possible as it can make your child feel different and allow muscles to weaken. Some families find that a wheelchair is useful occasionally to manage long walks or shopping trips when your child gets tired. However, it is important not to rely on a wheelchair. Special splints to support wrists or legs are sometimes helpful. Some children wear a wrist splint occasionally at school to rest the wrist while keeping the fingers free to write. Sometimes a splint is used for the back of the leg to keep the knee stretched, especially at night. Crutches are usually only recommended after surgery. Your occupational

therapist can suggest aids or adaptations to help your child at home or school. Special seating or a tilting desk may be useful. The occupational therapist can also advise on how your child can manage normal day-to-day activities without damaging their joints, causing pain or using up too much energy.

What helps reduce the pain?

The best way to relieve your child's pain is by controlling the arthritis with the right medicines and improving muscle strength to protect the joints through exercises. But if your child's joints are occasionally painful you can try applying heat or cold packs. Always wrap ice packs in a wet cloth to prevent freeze burns. If the pain is bad, you can alternate the packs (hot and cold) for 10 minutes each. Some children find a TENS (transcutaneous electrical nerve stimulator) machine helps relieve pain at particular points, but this should only be used after discussion with your doctor.

How often will my child have to visit hospital?

Your child will need to visit hospital regularly for check-ups and exercise advice. Usually this means going every 3-6 months to an outpatients department for specialist advice. Your child may see physiotherapists and occupational therapists in between times.

Will my child have to stay in hospital?

Children with arthritis rarely have to stay overnight in hospital. This usually only happens if a child is very ill with systemic arthritis or if it is more convenient to stay a few days while having various tests and treatments. Hospitals can facilitate parents to stay with their child and will also provide facilities for play and school lessons.

What about healthy living?

Just like any growing child, your daughter or son needs a healthy lifestyle with regular exercise, sleep and rest, and a balanced diet, with plenty of fruit, vegetables and fibre. Dairy foods, like milk, cheese and yoghurt, provide calcium to help prevent later osteoporosis. Foods rich in



protein, like meat, fish, eggs and cheese, help boost your child's energy levels. Some children benefit from food supplements, like Complan, to increase calorie intake while ill. Iron-rich foods, like meat, fish, green vegetables and beans, help avoid anaemia. Iron tablets are not normally needed. If your child eats well s/he should not need extra vitamins. In a few children, tablets containing calcium and vitamin D are recommended. There is no evidence that children with JIA benefit from a special diet or by avoiding certain foods. Indeed it can be harmful to cut out particular foods where these may be needed for your child's health.

Putting on too much weight can be a problem if your child is on steroids or is inactive for a long time.

Steroids can increase your child's appetite. It is important to avoid putting on too much weight as this puts extra stress on the joints. If weight does become a problem, the best advice is to keep offering a healthy diet and avoid junk foods and other foods which are high in sugar or fat. Healthy snacks like fruit, nuts and cereals are better than biscuits or crisps. Your hospital dietician can offer more advice. Exercise is also important in this respect.

Children with JIA do not need extra rests unless they are in a bad phase of their arthritis and feeling ill, or particularly tired. Indeed, keeping going can help improve stamina.

For further information on healthy eating, see Arthritis Ireland's booklet *'Healthy Eating and Arthritis'* or www.arthritisireland.ie.

Dental care

Children with JIA tend to have more trouble with their teeth, partly because of difficulty brushing. Care should be taken with this and they should have regular check-ups with a dentist.

Can complementary therapies help?

You may hear, or read on the internet, about complementary or alternative therapies which claim to treat JIA. You may even hear about therapies which promise miracle cures. It is important to treat these claims with caution. There is currently no cure for JIA, either in mainstream or complementary medicine.

Mainstream medicines are tested for safety and effectiveness in large-scale research trials. There are very few such trials which test the safety or effectiveness of complementary therapies for JIA. So far, there is no evidence that any complementary therapies can successfully treat JIA. Although complementary therapies are often described as 'natural', some can contain toxic substances which could harm your child. It could be extremely dangerous to stop your child's medicines. You should talk to your doctor if you are considering this.

However, many people do like the 'holistic' approach common to complementary therapies, which focuses on the person as a whole and not just their illness. You certainly may find some complementary therapies help to reduce pain or stiffness or help your child relax and feel better about his or her condition.

Relaxation therapies like yoga, t'ai chi, aromatherapy or massage may be useful. One study, reported in 1997, found that massage by parents for 15 minutes a day reduces a child's pain and stress. Finding a therapy which helps is really a matter of personal choice for you and your child. It makes sense to talk to your doctor before trying something new.

LIVING WITH JUVENILE IDIOPATHIC ARTHRITIS

How will juvenile idiopathic arthritis affect family life?

Looking after a child who is ill, for a short or a longer period, is hard on the whole family. For your child, there may be lots of emotional difficulties in growing up while being unable to do everything other children can do. For you as parents, it can be frustrating and tiring to cope with the ups and downs of your child's illness, hospital appointments, daily exercises, school matters and finances. While brothers and sisters can be very supportive, they may feel they get less time or attention than their sibling. Your health team, support groups and other families in the same situation can help you talk through these issues. If you feel that you would benefit from talking to another family of a child with JIA, Arthritis Ireland's *Parent to Parent Network* can help put you in touch with them. Although it is not all plain sailing, some families find the experience of having a child with JIA makes them stronger.

Trying to stay positive is a good start. Encourage your child not to see him or herself as 'ill' or 'a patient' when doing ordinary things like playing with friends, going to school, or tidying his or her room. However, arthritis in children can be unpredictable. Decide on the day whether to go to the seaside or cinema. Hospital appointments will make demands on your time. But it is important still to find time for yourself, for your partner, if you have one, and other children in the family. Try to find some special time for the other children, and make sure they have treats too, so they do not feel left out.

Your hospital team can help you as a family cope with everything your child's illness means, not just the medical treatment. The team may include a psychologist who can help you talk through any worries at any time. A social

worker can help with practical matters such as finding out about benefits. Social workers also help with parental counselling and support. But any member of the team will always be ready to discuss any problems that arise. If your child has just been diagnosed with JIA you may find it helpful to talk to another family who have already been through the experience. Your own family and friends are also an important resource. Grandparents, aunts and uncles are often happy to baby-sit or take other family members out occasionally. Do take up offers of help from friends and neighbours.

'Arthritis Ireland helped me find out what financial supports are available when your child has arthritis'

Arthritis Ireland's Helpline provides practical and emotional support to the families of children with arthritis and can be contacted **Monday to Friday from 10am to 4pm** on **LoCall 1890 252846**.

Arthritis Ireland run a dedicated *Juvenile Arthritis Programme*, which supports children and teenagers with arthritis and their families by providing a full range of innovative educational and support services. For further details call **(01) 6618188** or email ja@arthritisireland.ie.

What financial help is available?

You may be able to apply for state benefits to help with the extra costs of having a child with arthritis. The Citizens Information Board offer a comprehensive booklet that outlines all entitlements for people with a disability. You can get this booklet, *Entitlements for People with Disabilities*, by visiting your local office or contacting them on **LoCall 1890 777 121** or www.citizensinformation.ie.

Some of the main disability-related payments are:

Welfare Allowances

- **Domiciliary Care Allowance** is a monthly allowance paid by the Department of Social and Family Affairs to the carer of a child who is aged under age 16, who has a severe disability and who meets the conditions. The means of parents are not considered. Only the personal means of the child are taken into account. When your child reaches the age of 16 they may be entitled to Disability Allowance. If your child takes up employment, it may affect their weekly allowance, which can be paid to people with a disability who are between 16 and 65 years of age.
- **Carer's Allowance** is a means-tested payment to people in Ireland who are looking after someone who is in need of support because of age, physical or learning disability or illness. It is mainly aimed at carers on low incomes who live with and look after certain people who need full-time care and attention. The person being cared for must be over the age of 16 and so incapacitated as to require full-time care and attention or be aged under 16 and be in receipt of a Domiciliary Care Allowance.

Health Service

- **Medical Cards:** Most medical cards are granted on the basis of a means test and/or medical need. Each case is decided on its merits but you may qualify if your income is not much above the guideline figure and your medical costs are exceptionally high. It may be possible for one or more members of a family (who would not otherwise qualify) to get a medical card in their own right if they have high medical expenses or needs.
- **GP Visit Cards:** The purpose of the card is to help people who are not eligible for medical cards with the costs of visiting a doctor. The card covers you for GP visits but nothing else. The income guidelines for the



GP visit card are 50% higher than the medical card income guidelines.

- **Drugs Payment Scheme:** With a Drugs Payment Scheme (DPS) card, an individual or family in Ireland only has to pay a maximum amount monthly for approved prescribed drugs, medicines and certain appliances. As of January 2009, the maximum amount a family must pay is €100. Everyone in Ireland who doesn't have a medical card should apply for the DPS card.
- **Hospital Charges:** Everyone resident in Ireland is entitled to be treated free of charge in a public bed in a public hospital. Some people may have to pay maintenance charges. Out-patient services, when you are referred by your GP, are also provided free of charge.
- **Tax relief:** You may get tax relief on certain health expenses, which you have incurred for you or on someone else's behalf and for which you have not been reimbursed. The tax relief is at the standard rate of tax of 20%. So, if you spent €1,000 you would get a refund of €200. This claim should be made on a Med 1 form, available from your local tax office or online at www.revenue.ie.

Claiming benefits can be complicated and time-consuming, so it's worth getting expert help and advice from:

- a social worker from your local Health Office.
- a housing welfare officer from your local authority

- your citizens information service: **LoCall 1890 777 121**
- your local social welfare office
- the Leaflet Request Line in the Department of Social & Family Affairs: **LoCall 1890 20 23 25**
- the Health Service Executive at **www.hse.ie**.

How will my child cope with school?

Most children with JIA manage perfectly well in mainstream school. Better treatment means only very few children – those with severe arthritis – need to go to a special school. However, schools do vary in how well they are geared up to help your child. Your hospital team might liaise with the school to help teachers understand your child's illness and needs. This will ideally include assessment and co-ordination by an occupational therapist.

As your child may miss out on lessons through illness or hospital appointments, it is important to inform his or her teacher as soon as a diagnosis has been made. Being included in all school activities, in as normal a way as possible, is essential to promoting and supporting a child's self-esteem. The school should be understanding about this and provide extra help if needed.

What can schools do to help?

There is a range of ways in which schools can help a child with arthritis. This varies according to the individual child's needs. A child with mild arthritis may not need extra help in class, but it is still useful for teachers to be informed of the diagnosis. A child with more severe arthritis may need extra support, either temporarily or long-term. This might be the use of a laptop in class, adaptations to tables and chairs, or classroom help from a special needs assistant.

Naturally, teachers, and will want to discuss a child's individual needs with his or her parents. The child's physiotherapist or occupational therapist can also offer advice and, in some cases, visit the school to discuss the child's needs and assess what help can be given. It is also recommended, and makes good sense, that the child be involved in the discussions. Even young children have a view on what they find difficult and how they might be helped. For example, if a child dislikes a particular change or piece of equipment, s/he is unlikely to adapt to or use it. At your request, Arthritis Ireland will liaise with schools to fully inform your child's teachers and fellow students about living with juvenile arthritis by giving educational talks, and providing schools with information and support.

Mobility

The most common difficulty for a child with arthritis is getting around. Painful joints can make movement more difficult or slower. The child may need transport to and from school, so as to reserve his or her energies for the classroom. Schools may need to be flexible about a child arriving late or leaving early. If a school trip involves walking, transport may need to be arranged. Letting the child get up and walk around in class can help reduce stiffness. Desks and chairs may need raising or lowering to provide the best seating position. If children find sitting on the floor difficult during assembly or carpet time, they may need to be provided with a chair.

Help or extra time moving between lessons is useful. This is less of an issue in primary school, where schools are generally smaller and lessons often in the same room. However, a ground-floor classroom is helpful. In secondary schools, where lessons are often in different rooms, a pupil may need extra time for changing lessons. Allowing a pupil to leave lessons earlier, perhaps using a card s/he shows to the teacher, is a good idea. This helps them avoid the crush as well as coping with long walks and stairs. It can be helpful to let a friend go with them. Again it is helpful if lessons can be based in ground-floor rooms wherever possible.



Providing a ground-floor locker helps avoid carrying lots of bags around. Allowing a pupil to leave textbooks in a classroom and have two sets of books – for school and home – also reduces the carrying burden. It may be useful to let a pupil work in the library if this is more comfortable. Where there are lifts the pupil should be allowed to use these. Sometimes a grab rail in toilets or a banister on both sides of stairs is recommended. Few children with arthritis today use crutches or wheelchairs, but if these are needed then access needs to be considered.

The child's occupational therapist can advise on adaptations or equipment, which may be useful.

Hand function

Painful hand and wrist joints can make fine manipulative tasks difficult. A child may write more slowly than classmates or need breaks to rest the joints. Occasionally, a child may wear a wrist splint or brace to support the wrist while writing. Allowing the child to do oral work, using tapes or allowing them to dictate work, can help. It may be helpful to provide photocopies of any long text, which needs to be copied down. Some children find using a computer keyboard or laptop easier for at least some of the time. The child may need extra time to finish work and to complete exams.

As previously mentioned, s/he may also need extra time or help with buttons, going to the toilet and other everyday activities such as opening lunchboxes. The child's occupational therapist can recommend special

aids, like easy-grip scissors and cutlery, pencil grips and tap turners. Some children may need a special needs assistant to help with tasks like carrying books, taking notes and using equipment, on either a part-time or a full-time basis.

Breaks

Children with arthritis should join in playtime or breaks, just like their classmates, whenever possible. Exercise is good for arthritis and joining in helps the child avoid feeling different. Sometimes, however, they may find running about or standing around painful. Cold weather can make joint stiffness worse. It may help to allow the child, along with some of his or her friends, to play inside for some or all of break-time.

'Communication is key: we keep in regular contact with our child's teacher'

PE and sports

As previously mentioned, exercise is vital for children with arthritis. They should be encouraged to take part in PE lessons and other sports activities as much as possible. They should generally be able to join in all sporting activities, apart from rough contact sports like rugby. Swimming and cycling are especially good. However, if the child is finding PE difficult s/he should be allowed to do his or her own exercise programme instead. The child's physiotherapist can advise on PE and exercises. In some cases physiotherapists may come into school to treat a child while the rest of the class has PE.

Extra tuition

Arthritis does not in itself affect a child's capacity for academic achievement. However, missing school through hospital visits or stays may mean a child falls behind.

In this case they will need work sent home to help them catch up. If they fall seriously behind they may need extra tuition at home.

Staying in hospital

Some children may occasionally stay in hospital for tests or treatment. They may miss school for a few days or weeks, possibly on a regular basis. Hospital tutors will make sure they do not fall behind with their schoolwork. Ideally this should be done in liaison with the child's own school, to ensure continuity of education. If possible teachers should arrange work for the child to take into hospital. For children who have been very ill and in hospital for long periods of time, a discharge planning meeting or case conference may be held. It is very helpful if a member of staff from school can participate in these meetings.

Classmates

Other children are generally supportive of a child's particular individual needs when they understand the reasons. Discussing arthritis with the whole class is a good idea. A local physiotherapist or occupational therapist may be willing to come and talk. Any incidents of teasing or bullying should be tackled, as for any other child, immediately.

Emotional issues

As with any long-term illness, arthritis can cause emotional difficulties, especially as children grow older. A child may be anxious about the future, worried about hospital appointments, or distressed about falling behind. S/he may resent feeling different or enjoy the extra attention illness can bring. The general approach adopted by professionals treating arthritis in children is to encourage a child to be positive and not see himself or herself as a 'patient' all the time. A child may need reassurance and motivation to catch up or join in. A child's illness can affect the whole family, so schools may need to be aware of the effect on the child's siblings too.

Moving to secondary school

Moving from primary to secondary school needs careful and early planning. Secondary school children have to cope with more stairs, more pupils, and more moving around between lessons. It is a good idea to talk to schools early – at the end of fifth class or beginning of sixth class – to make sure they are prepared. Arthritis should not affect how well your child does at school. Children with JIA do just as well as their classmates in exams and many go on to further education at college or university without any problems.

Growing up

As they grow older, children with arthritis may experience additional challenges. For some, puberty can be delayed for a few years. Physical difficulties may limit them joining in with their peers or gaining independence. Bullying or teasing at school is a problem for some youngsters. Some teenagers find that 'disclosure' – telling friends, partners or teachers about their arthritis – is difficult. Support from school staff, in liaison with parents, is vital at this stage.

Career advice

Children with arthritis often do well academically and many go on to university or college. But some seem to have difficulties obtaining a job, possibly because employers have lower expectations or because of prejudice. Helping a child plan a suitable future career early on, and boosting their expectations and self-esteem, may make a huge difference.

How will juvenile idiopathic arthritis affect my child growing up?

Most children grow out of JIA as they move towards their teens and will eventually be discharged from hospital care. About a third will have some continuing problems as they become teenagers and young adults. Your child

may have growth problems if their arthritis is not well controlled or if they have to take steroid tablets for long periods. These circumstances may mean they are shorter than classmates. Sometimes it means one limb ends up shorter, or even longer, than another. In children with systemic JIA, growth is often reduced until the disease is brought under control. Once the illness is treated adequately, growth can increase and many children catch up. If growth is badly affected, treatment using growth hormone may be an option. Your son or daughter will need reassurance that they can catch up.

Growing up with a long-term illness is challenging. Your son or daughter will need encouragement to do things for him or herself, like going out alone, arranging social activities and coping with money, like any growing child. S/he also needs to take more responsibility for his/her own treatment. As they gain independence they may become less keen to do exercises or take medicines, so it is important they understand the reasons for treatment and the possibility that their arthritis may get worse if they miss treatment. Prioritising therapies and negotiating breaks from therapy can be useful compromises.

Growing up also means moving from child to adult hospital care. This should be a gradual change towards attending hospital appointments on their own and making their own decisions about treatment. Children mature at different rates, but research shows a gradual move towards independence should start early, at around 11 years, as they enter secondary school.

Many teenagers seem more willing than their parents to take on independence. As a parent – who may have given up a lot to help your child through illness – it can be hard to let go. You do need to be supportive and respect your son or daughter's move towards adulthood. Talking this over with your hospital rheumatology team may be helpful.



What about becoming a teenager?

Becoming a teenager can be full of anxieties for any young person and his or her family. Children with arthritis are no different and so family tensions can be heightened at this time. Coping with arthritis may add extra challenges. Your hospital rheumatology team can offer support in dealing with any issues that may arise.

‘As our daughter has grown, we’ve allowed her to make some decisions about her care and she has responded well to the new responsibility’

Arthritis, and some drug treatments, can delay puberty for a few years in some children. Girls may begin their periods and develop breasts later. For boys, facial hair and voice-breaking may happen later. Since most teenagers are very conscious of their bodies, and body image, and want to be like their friends, this can be upsetting. They may need lots of reassurance and confidence-boosting. Bullying or teasing at school has been found to be a problem for some young people. Talking about this with a parent, teacher or friends is the first step to stopping it. Some



teenagers may find that 'disclosure' – telling friends, partners or employers about their arthritis – is difficult. You can help by talking through how to broach the subject.

Some young people will find that arthritis causes physical problems, which limit what they can do. Helping your son or daughter fit in with social activities or find alternatives is important. Like many teenagers, your daughter or son may be tempted to try cigarettes, alcohol or illegal drugs. It is best to be honest and open about the risks without laying down the law, just as with any teenager. But your teenager also needs to know the extra risks in drinking alcohol or having unprotected sex while taking their medication. Taking alcohol and methotrexate together can cause liver damage. However, avoiding alcohol altogether is very difficult for young people trying to fit in with their friends. Indeed, many young people do drink small amounts of alcohol while on methotrexate without any liver damage. A sensible limit would be 4 units of alcohol a week. One unit is 1/2 pint of 'normal'-strength beer or lager (3.5% abv), a small glass of wine (12% abv), or a single measure of a 'short' like gin or vodka (40% abv).

Another concern for young people is unprotected sex. Getting pregnant or fathering a child while taking methotrexate, or within 6 months after taking it, can cause harm to the baby. Young people on methotrexate should always use contraceptives if having sex. If your son or daughter has unprotected sex they should see a nurse or doctor urgently. It makes sense to talk to your daughter or son about the need for protection before you think they might be having sex.

Learning to drive can be a lifeline, not only in helping young people get around more easily but as a boost to their independence. Planning for the future is also important. While children with JIA often do well at school, they may find later difficulties getting a job. This could be due to lower expectations from parents, teachers or the teenagers themselves, lack of work experience, difficulties putting themselves forward, or prejudice in the outside world. It makes sense to help your teenager think early on about a future career, to boost their expectations and self-esteem and, if possible, help them gain some job experience, such as babysitting or voluntary work. Find out more about teenage years in Arthritis Ireland's booklet '*When a Teenager has Arthritis*' or on www.arthritisireland.ie.

LOOKING AHEAD

Treatment of childhood arthritis has made great strides in recent years. Better understanding of the illness and new medicines are making a huge difference to youngsters' prospects. Finding out your child has JIA can be worrying. But there are lots of reasons to be positive about the future and there are many people – professionals, volunteers and other families – ready and willing to help you. Arthritis Ireland run a dedicated *Juvenile Arthritis Programme*, which supports children and teenagers with arthritis and their families by providing a full range of innovative educational and support services. For further details call **(01) 6618188** or email ja@arthritisireland.ie.

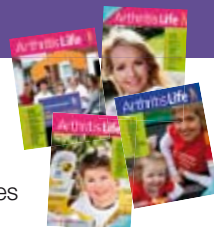
For further information on how **Arthritis Ireland** can help you live your best possible quality of life, contact us on **LoCall 1890 252846** or visit our website at www.arthritisireland.ie.

5 Great Reasons a friend

Sign up today for

to become
of Arthritis Ireland
just €3 a month

A person with arthritis who is well informed about their condition is more likely to lead a better quality of life*. Becoming a FRIEND of Arthritis Ireland is an easy way of staying up to date while helping us to make a real difference to the lives of people living with arthritis.



1 Receive a year's free subscription to Arthritis Life:

The only magazine in Ireland that addresses the interests of people with arthritis and provides regular updates on our work and events.

2 Stay informed about Arthritis Ireland courses and events:

Be the first to receive notifications of the education courses, seminars and activities running in your area.

3 Have your say:

Have the opportunity to become a member of Arthritis Ireland and be more actively involved if you wish.

4 Receive a free arthritis friendly key turner**:

Receive a FREE key turner to give an easier grip and better leverage when turning keys.



5 Help make a real difference for just €3 per month:

For just €3 per month you will help us provide vital education and support services to empower people with arthritis by giving them the knowledge they need to take back control of their disease and their life. Your donation of €36 will enable us to provide information packs to 10 people like you living with this chronic condition.

* Research by: People with Arthritis/Rheumatism in Europe (PARE).

** Free gifts are subject to change and supply.

For more details of how your donation makes a difference to the lives of people living with arthritis, just log on to www.arthritisireland.ie

Become a friend of Arthritis Ireland today

In addition to the fantastic range of benefits you receive, you are also helping to make a real difference to the lives of people living with arthritis.

☐ Yes, I would like to become **a friend** today for just €3 per month or €36 per year.

☐ I would like to make a gift of

€ _____

in support of the 1 in 6 people in Ireland with arthritis.

Personal Details: (please fill in all areas)

Name:

Address:

Telephone:

Email:

D.O.B.:

Do you have arthritis?

If so, what type?

Would you like to become a **MEMBER** of Arthritis Ireland at **NO EXTRA COST**? Just tick the box and we will forward you full details. ☐

☐ Payment by **Standing Order:**

Standing Order is cost effective, convenient, and confidential, please fill in details below

Bank Name:

Bank Address:

Your current account no:

Sort Code:

 – –

Name of account holder:

Address (if different than above)

Signature:

Date:

Please pay to: AIB, 52 Upper Baggot Street, Dublin 4, Sort: 93-10-63, for the credit of Arthritis Ireland.

Account no: 00373035 **Reference:** Arthritis Ireland Friends

☐ Payment by **Cheque or Postal Order:**

Please make payable to Arthritis Ireland

☐ Payment by **Credit Card:**

Please charge my: VISA / MasterCard / Laser
(please circle)

Credit Card Number:

Expiry Date:

CVV: (3 digits on reverse)

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1 Clanwilliam Square, Grand Canal Quay, Dublin 2.**
Using a stamp on your return envelope will help us save costs.

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